Harrisonburg Dietitians, LLC
2040 Deyerle Avenue Suite 106 Harrisonburg, VA 22801
540-437-9575 540-437-9576 (fax)

Medical Nutrition Therapy Registration Form

Appointment time and date: ____________________________ MD: _____________

Patient's Name: ____
First Middle Last

Mailing address: ____

Home phone# ____________________________ Work # ____________________

E-Mail (for nutrition newsletter and special events): __________________________________

Date of Birth: ______________ Age: ________ Social Security # _____________

☐ Male ☐ Female ☐ Married ☐Single ☐Divorced ☐Widowed

Occupation: _____________________________________ ☐ Full Time ☐ Part Time

Employer's Address: ____

Employer's Phone#: ____

May we leave a message on your answering machine? ☐yes ☐no

Person Responsible for Payment

Name: ____
First Middle Last

DOB: _________________________ Mailing Address:_______________________________

____

Home Phone#:_______________________________ Work#: ____________________

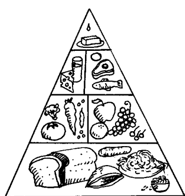
Social Security # ________________________ Relationship to Patient: ________________

Do you have Medicare benefits? ☐ yes ☐ no

Payment is expected at time of service. A receipt will be provided to you for insurance and/or flexible spending account reimbursement if applicable.

By signing this form, you acknowledge that a copy of this practice's Notice of Privacy Practices (required by HIPPA) has been provided to you, that you had the opportunity to ask questions and that all your questions have been answered.

____ ________________________



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Patient's or Guardian's Signature Date Signed

Assignment and Release

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment promptly upon presentment thereof. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendancy of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency I agree to pay all costs of collection, including agency fees and 25 percent attorney fees.

Signature of Insured/Guardian: ______________________Date: _________________

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me on my behalf or to Harrisonburg Dietitians, LLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits or these benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: ________________________________ Date: ____________